



# **YOUR GROUP INSURANCE PLAN BENEFITS**

**NATIONAL SEATING & MOBILITY  
CLASS 0001  
CRITICAL ILLNESS**

The enclosed certificate is intended to explain the benefits provided by the Plan. It does not constitute the Policy Contract. Your rights and benefits are determined in accordance with the provisions of the Policy, and your insurance is effective only if you are eligible for insurance and remain insured in accordance with its terms.

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## CERTIFICATE OF COVERAGE

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### The Guardian

7 Hanover Square  
New York, New York 10004  
1-(888)-482-7342

The group Critical Illness coverage described in this Certificate is attached to the group Policy effective January 1, 2019. This Certificate replaces any Certificate previously issued under this Plan or under any other plan providing similar or identical benefits issued to the planholder by Guardian.

**Important Notice: This is a limited plan of Critical Illness insurance. It is a supplement to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance. Please read this Plan carefully to fully understand what it covers, limits, and excludes. THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.**

### GROUP CRITICAL ILLNESS COVERAGE

Guardian certifies that the Employee to whom this Certificate is issued is entitled to the benefits described herein. However, the Employee must: (a) satisfy all of this Plan's eligibility and effective date requirements; (b) be listed in Our and/or the Policyholder's records as a validly covered Employee under this Plan; and (c) all required premium payments must have been made by or on behalf of the Employee.

The Employee and/or his or her Dependents are not covered by any part of this Plan for which he or she has waived coverage. Such a waiver of coverage is shown in Our and/or the Policyholder's records.

Policyholder: NATIONAL SEATING & MOBILITY

Group Policy Number: 00553700

*Stuart J Shaw*  
Vice President, Risk Mgt. & Chief Actuary

B044.0005



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## DEFINITIONS

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This section defines certain terms appearing in Your Certificate.

B040.0004

**Active Work or Actively At Work:** These terms mean Your performance of all the duties that pertain to Your work at the place: (1) where it is normally done; or (2) where it is required to be done by Your Employer.

B040.0882

**Board Certified:** This term means a Doctor who has been certified in the appropriate medical specialty by a member board of the American Board of Medical Specialties.

B005.0010

**Covered Dependent Child:** This term means Your eligible dependent child covered under this Plan.

B005.0011

**Covered Person:** This term means You, if You are covered under this Plan and Your covered dependents.

B005.0012

**Critical Illness:** This term means any of the conditions shown in the Covered Critical Illnesses section of this Plan.

B005.0013

**Diagnosis:** This term means the establishment of a Critical Illness by a Doctor through the use of clinical and/or lab findings, as described in the Covered Critical Illnesses section of this Plan.

B005.0042

**Doctor:** This term means any medical practitioner We are required by law to recognize. He or she must: (1) be properly licensed or certified by the laws of the state where he or she practices; and (2) provide services that are within the lawful scope of his or her practice.

B005.0014

**Domestic Partner:** This term means an opposite or same sex partner who has met all of the following requirements for at least 12 months: (1) resides with the Covered Person; (2) shares financial assets and obligations with the Covered Person; (3) is not related by blood to the Covered Person to a degree of closeness that would prohibit a legal marriage; (4) is at least the age of consent in the state in which they reside; and (5) neither the Covered Person or Domestic Partner is married to anyone else, nor has any other Domestic Partner. The Company requires proof of the Domestic Partner relationship in the form of a signed and completed Affidavit of Domestic Partnership.

B005.0015

**Eligibility Date:** For Employee coverage, this term means the earliest date You are eligible for coverage under this Plan. For dependent coverage, this term means the earliest date on which: (1) You have Initial Dependents; and (2) are eligible for dependent coverage.

B005.0016

**Employee:** This term means a person who works for the Employer and whose income is reported for tax purposes using a W-2 form.

B005.0018

**Employer:** This term means NATIONAL SEATING & MOBILITY .

B005.0019

**Enrollment Period:** This term means the 31 day period which starts on the date You first become eligible for dependent coverage.

B005.0020

**Full-Time:** This term means You regularly work at least the number of hours in the normal work week set by the Employer (but not less than 30 hours per week), at: (1) Your Employer's place of business; (2) some place where the Employer's business requires You to travel; or (3) any other place You and Your Employer have agreed upon for the performance of occupational duties.

B005.0021

**Initial Dependents:** This term means eligible dependents You have at the time You first become eligible for Employee coverage. If at this time You do not have any eligible dependents, but You later acquire them, the first eligible dependents You acquire are Your initial dependents.

B005.0023

**Injury:** This term means: (1) all damage to a Covered Person's body due to an accident; and (2) all complications arising from that damage.

B005.0024

**Medically Necessary** This term means health services and supplies that are all of the following:

- (1) medically appropriate;
- (2) needed to Diagnose or treat a Sickness or Injury;
- (3) consistent in type, frequency, and length of treatment with scientifically based guidelines of national medical research or health care coverage organizations or government agencies;
- (4) needed for reasons other than comfort or convenience of the Covered Person or Doctor;
- (5) of proven medical value; and
- (6) done with the appropriate level of service or supply needed to provide safe and adequate care.

B005.0025

**Newly Acquired Dependent:** This term means an eligible dependent You acquire after You already have coverage in force for Initial Dependents.

B005.0026

**Plan:** This term means the group Critical Illness coverage plan described in the Policy and this Certificate.

B005.0028

**Proof of Insurability:** This term means the completion of an evidence of insurability form, acceptable to Us, showing that a person is insurable.

B005.0029

**Sickness:** This term means any illness or disease suffered by a Covered Person.

B005.0030

**Spouse:** This term means Your lawful spouse, which shall include the marriage between opposite or same-sex partners legally performed in other jurisdictions. This term shall also include registered Domestic Partners.

B005.0031

**We, Us, Our and Guardian:** These terms mean The Guardian Life Insurance Company of America.

**Your or Your:** These terms mean the insured Employee.

B005.0032

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## GENERAL PROVISIONS

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B005.0033

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### Applicable Benefits

This Certificate may include multiple benefit options and types of benefits. In the event that the Certificate includes such multiple benefit options and types of benefits, each Covered Person will only be covered for those applicable benefits that (1) were previously selected in a manner and mode acceptable to Guardian such as an enrollment form and (2) for which applicable premium has been received by Guardian.

B005.0034

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### Limitation of Authority

No person, except by a writing signed by the President, a Vice President or a Secretary of Guardian, has the authority to act for Us to: (1) determine whether any contract, Policy or certificate is to be issued; (2) waive or alter any provisions of any contract or Policy, or any of Our requirements; (3) bind Us by any statement or promise relating to any contract, Policy or certificate issued or to be issued; or (4) accept any information or representation which is not in a signed application.

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### Incontestability

The Policy is incontestable after two years from its date of issue, except for non-payment of premiums.

No statement in any application, except a fraudulent statement, made by a Covered Person will be used to contest the validity of his or her insurance or to deny a claim for a loss incurred after such insurance has been in force for two years during his or her lifetime.

If the Policy replaces a plan your Employer had with another insurer, we may rescind the Plan based on misrepresentations made by the Employer or an Employee in a signed application for up to two years from the effective date of the Plan.

In the event Your insurance is rescinded due to a fraudulent statement made in Your application We will refund premiums paid for the periods such insurance is void. The premium paid by You will be sent to Your last known address on file with Your Employer or Us.

B005.0036

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## **Examination and Autopsy**

We have the right to have a doctor of our choice examine the person for whom a claim is being made under the Plan as often as We feel necessary. We also have the right to have an autopsy performed in the case of death where allowed by law. We will pay for all such examinations and autopsies.

B005.0038

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## **Critical Illness Claims Provisions**

Your right to make a claim for Critical Illness benefits provided by the Policy is governed as shown below.

### **Notice**

You must send Us written notice of an Injury or sickness for which a claim is being made within 20 days of the date the Injury occurs or the sickness starts. This notice should include Your name and the Policy number. If the claim is being made for any other Covered Person, his or her name should also be shown.

### **Claim Forms**

We will furnish You with forms for filing proof of loss within 15 days of receipt of notice. If We do not furnish the forms on time, We will accept a written description and adequate proof of the Injury or sickness that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made.

### **Proof Of Loss**

You must send written proof to Our designated office within 90 days from the date we request it.

### **Late Notice Of Proof**

We will not void or reduce Your claim if You cannot send Us notice and proof of loss within the required time. In that case, You must send Us notice and proof as soon as reasonably possible.

### **Payment Of Benefits**

We will pay Critical Illness benefits as soon as we receive written proof of loss.

Unless otherwise required by law or regulation, We pay all Critical Illness benefits to You if you are living. If You are not living, We have the right to pay all Critical Illness benefits to one of the following: (1) Your estate; (2) Your spouse; (3) Your parents; (4) Your children; or (5) Your brothers and sisters.

### **Legal Actions**

No legal action against this Plan shall be brought until 60 days from the date proof of loss has been given as shown above. No legal action shall be brought against this Plan after three years from the date written proof of loss is required to be given.

#### **Workers' Compensation**

The Critical Illness benefits provided by this Plan are not in place of and do not affect requirements for coverage by Workers' Compensation.

B044.0006

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## ELIGIBILITY FOR CRITICAL ILLNESS - EMPLOYEE COVERAGE

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### Eligible Employees

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Subject to the conditions of eligibility set forth below, and to all of the other conditions of the Plan, You are eligible if You are in an eligible class of Employees and are an active Full-Time Employee.

If You are a partner or proprietor, We will treat You like an Employee if You meet the Plan's conditions of eligibility.

### Conditions of Eligibility

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You are eligible for Critical Illness coverage if You are;

- Legally working in the United States, or working outside of the United States for a United States based employer in a country or region approved by Us; and
- Regularly working at least the number of hours in the normal work week set by the Employer (but not less than 30 hours per week) at: (1) the Employer's place of business; (2) some place where the Employer's business requires You to travel; or (3) any other place You and the Employer have agreed upon for the performance of occupational duties.

You are **not** eligible for Critical Illness coverage if You are a temporary or seasonal Employee.

**Enrollment Requirement:** If You must pay all or part of the cost of Your coverage, We will not cover You until You enroll and agree to make the required payments.

**Proof of Insurability:** If You: (1) do not meet this Plan's enrollment requirement within 31 days after You first become eligible; or (2) enroll after You previously had coverage which ended because You failed to make a required payment, We will ask for Proof of Insurability. And, You will not be covered until We approve that Proof of Insurability in writing.

Part or all of Your insurance amounts may be subject to Proof of Insurability. The Schedule of Benefits explains if and when We require Proof of Insurability. You will not be covered for any amount that requires such Proof of Insurability until You give the Proof of Insurability to Us and We approve that Proof of Insurability in writing.

If Your active Full-Time service ends before You meet any Proof of Insurability requirements that apply You will still have to meet those requirements if You are later re-employed by the Employer or an associated company.

B005.0043

**The Waiting Period** If You are in an eligible class, You are eligible for Critical Illness coverage under this Plan after You complete the service waiting period, if any, established by the Employer.

B005.0045

**Multiple Employment** If You work for both the Employer and a covered associated company, or for more than one covered associated company, We will treat You as if only one firm employs You. You will not have multiple Critical Illness coverages under this plan. But, if this Plan uses the amount of Your earnings to set the rates, determine class, figure coverage amounts, or for any other reason, such earnings will be figured as the sum of Your earnings from all covered Employers.

B005.0046

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### **When Employee Coverage Starts**

Your eligibility date is the date You have met all of the conditions of eligibility.

Whether You must pay all or part of the cost of Your coverage, You must elect to enroll and agree to make the required payments before Your coverage will start. If You do this on or before Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You do this within 31 days after Your Eligibility Date, Your coverage is scheduled to start on Your Eligibility Date. If You elect to enroll and agree to make the required payments more than 31 days after Your Eligibility Date, Your coverage will not be scheduled to start until You send Us Proof of Insurability. Once We have approved such Proof of Insurability, Your coverage is scheduled to start on the effective date shown in the endorsement section of Your evidence of insurability form.

Any part of Your coverage which is subject to Proof of Insurability will not start unless You send such Proof of Insurability to Us, and We approve it in writing. Once We have approved it, that part of Your coverage is scheduled to start on the effective date shown in the endorsement section of Your evidence of insurability form. If Your active service ends before You meet any Proof of Insurability requirements that apply You will still have to meet those requirements if You are later re-employed by the Employer or an associated company.

On the date all or part of Your coverage is scheduled to start, You must be: (1) Actively At Work; (2) fully capable of performing the major duties of Your regular occupation; and (3) working Your regular number of hours. In that case, Your coverage will start at 12:01 A.M. Standard Time for Your place of residence on that date. In any other case, We will postpone the start of Your coverage until the date You: (a) return to Active Work; (b) are working Your regular number of hours; and (c) are fully capable of performing the major duties of Your regular occupation. Sometimes, a scheduled effective date is not a regularly scheduled work day. If the scheduled effective date falls: on a holiday; on a vacation day; on a non-scheduled work day; during a layoff of less than 180 days in duration; during an approved leave of absence not due to sickness or injury, of 90 days or less; or on a day during a period of absence that is less than 7 days in duration; and if: (a) You were fully capable of performing the major duties of Your regular occupation for the Employer on a full-time basis at 12:01 AM Standard Time for Your place of residence on the scheduled effective date; and (b) You were performing the major duties of Your regular occupation and working Your regular number of hours on Your last regularly scheduled work day; Your coverage will start on the scheduled effective date.

**Delayed Effective Date For Voluntary Critical Illness Coverage:** If You are not Actively At Work on the date Your Voluntary Critical Illness coverage is scheduled to start due to Sickness or Injury, We will postpone coverage for an otherwise covered loss due to that Sickness or Injury. We will postpone such coverage until You complete ten days in a row without missing a work day due to that Sickness or Injury in which You are: (1) Actively At Work; (2) fully capable of performing the major duties of Your regular occupation; and (3) working Your regular number of hours. Coverage for an otherwise covered loss due to all other conditions will start on the date You are: (a) Actively At Work; (b) fully capable of performing the major duties of Your regular occupation; and (c) working Your regular number of hours.

**Exception to When Employee Coverage Starts:** If You are not capable of performing the major duties of Your regular occupation for Your Employer on a full-time basis on the date Your coverage is scheduled to start, You will be insured for Critical Illness insurance if:

1. You were insured under the prior insurer's group critical illness policy at the time of the transfer;
2. You are a member of an eligible class; and
3. premiums for You were paid up to date; and
4. You are not receiving or eligible to receive benefits under the prior insurer's group critical illness policy.

Any Critical Illness benefit payable will be the lesser of:

1. the Critical Illness benefit payable under the Group Policy; or
2. the critical illness benefit payable under the prior insurer's group critical illness policy had it remained in force.

The Critical Illness benefit payable will be reduced by any amount paid by the prior insurer's group critical illness policy.

All other provisions under this Policy will apply under the Exception to When Employee Coverage Starts.

You will remain insured under this provision until the first to occur of:

1. the date You are fully capable of performing the major duties of Your regular occupation for Your Employer on a full-time basis;
2. the date insurance terminates for one of the reasons stated in When Employee Coverage Ends;
3. the last day of a period of 12 consecutive months which begins on the Policy effective date; or
4. the last day You would have been covered under the prior insurer's group critical illness policy, had the prior plan not terminated.

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### **When Employee Coverage Ends**

Your coverage will end on the first of the following dates:

- The date in which Your active full-time service ends for any reason. Your active service ends when You are no longer: (1) Actively At Work; and (2) working Your regular number of hours.
- The date You stop being an eligible Employee under this Plan.
- The date You are no longer working in the United States or working outside of the United States for a United States based Employer in a country or region approved by Us.
- The date the group Plan ends, or is discontinued for a class of Employees to which You belong.
- The last day of the period for which required payments are made for You.

B005.0050

#### **Your Right to Continue Critical Illness Coverage During a Family Leave of Absence**

**Important Notice:** This section may not apply to Your Employer's Plan. You must contact Your Employer to find out if he or she must allow for a family leave of absence under federal law. If he or she must allow for such leave, this section applies.

**If Your Coverage Would End:** Your Critical Illness coverage would normally end because You cease work due to an approved leave of absence. But, You may continue Your coverage if the leave has been granted: (1) to allow You to care for a seriously injured or ill spouse, child or parent; (2) after the birth or adoption of a child; (3) due to Your own serious health condition; or (4) because of a serious Injury or illness arising out of the fact that Your spouse, child, parent or next of kin who is a covered service member is on active duty, or has been notified of an impending call or order to active duty, in the Armed Forces in support of a contingency operation. To continue Your coverage, You will be required to pay the same share of the premium as You paid before the leave of absence.

**When Continuation Ends:** Continued coverage will end on the earliest of the following:

- The date You return to Active Work.
- In the case of a leave granted to You to care for a covered service member, the end of a total leave period of 26 weeks in one 12 month period. This 26 weeks total leave period applies to all leaves granted to You under this section for all reasons. If You take an additional leave of absence in a subsequent 12 month period, continued coverage will cease at the end of a total leave period of 12 weeks.
- In any other case, the end of a total leave period of 12 weeks in any 12 month period.
- The date on which Your Employer's Plan is terminated or You are no longer eligible for coverage under this Plan.
- The end of the period for which premium has been paid.

**Definitions:** As used in this section, the terms listed below have the meanings shown below:

- **Active Duty:** This term means duty under a call or order to active duty in the Armed Forces of the United States.
- **Contingency Operation:** This term means a military operation that: (1) is designated by the Secretary of Defense as an operation in which members of the Armed Forces are or may become involved in military actions, operations or hostilities against an enemy of the United States or against an opposing military force; or (2) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law or during a national emergency declared by the President or Congress.
- **Covered Service Member:** This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a Serious Injury or Illness is: (1) undergoing medical treatment, recuperation or therapy; (2) otherwise in Outpatient Status; or (3) otherwise on the temporary disability retired list.
- **Next Of Kin:** This term means Your nearest blood relative.
- **Outpatient Status:** This term means, in the case of a covered service member, that he or she is assigned to: (1) a military medical treatment facility as an outpatient; or (2) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.
- **Serious Injury Or Illness:** This term means, in the case of a Covered Service Member, an Injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her: (1) office; (2) grade; (3) rank; or (4) rating.

B005.0062

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## **ELIGIBILITY FOR CRITICAL ILLNESS COVERAGE - DEPENDENT COVERAGE**

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B005.0063

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### **Eligible Dependents for Dependent Critical Illness Coverage**

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B005.0064

**Eligible Dependents for Voluntary Dependent Critical Illness** Your eligible dependents are Your spouse and unmarried dependent children from birth until they reach age 26.

B005.0080

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### **Adopted Children and Step-Children**

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Your "unmarried dependent children" include Your legally adopted children, and Your step-children. But, Your step-children must depend on You for most of their support and maintenance. We treat a child as legally adopted from the time the child is placed in Your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

B005.0065

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### **Dependents Not Eligible**

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We exclude any dependent who is on active duty in any armed force. And, We exclude any dependent who is covered by this Plan as an Employee.

A child may be an eligible dependent of more than one Employee who is insured under this Plan. In that case, the child may be insured for dependent Critical Illness benefits by only one Employee at a time.

B005.0066

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### **Disabled Children**

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You may have an unmarried child who is: (a) incapable of self-sustaining employment by reason of a mental, intellectual or physical disability or developmental disability; and (b) chiefly dependent upon You for support and maintenance. In that case such a child may remain eligible for dependent benefits past the age limit subject to the conditions shown below.

- His or her condition started before he or she reached the age limit.
- He or she became covered for dependent Critical Illness benefits before he or she reached the age limit.

- He or she stays unmarried and remains: (i) incapable of self-sustaining employment; and (ii) dependent upon You for most of his or her support and maintenance.
- You send Us written proof, and We approve such proof, of the child's disability and dependence within 31 days from the date he or she reaches the age limit. After the two year period following the child's attainment of the age limit, We can ask for periodic proof that the child's condition continues, but We cannot ask for this proof more than once a year. The child's coverage ends when Your coverage ends.

B044.0009

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## **Proof of Insurability**

We require Proof of Insurability that a dependent is insurable if You: (1) enroll a dependent who was previously declined or would have been considered a late enrollee under a group critical illness coverage plan providing dependent coverage which this Plan replaced; (2) enroll a dependent and agree to make the required payments after the end of the Enrollment Period.

A dependent is not covered by any part of this Plan that requires such Proof of Insurability until You give Us this Proof of Insurability and We approve it in writing.

If Your dependent coverage ends for any reason, including failure to make the required payments, Your dependent will not be covered by this Plan again until You give Us new Proof of Insurability that they are insurable and We approve that Proof of Insurability in writing.

B005.0069

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## **When Dependent Coverage Starts**

In order for Your dependent coverage to start, You must already be covered for Employee coverage, or enroll for Employee and dependent coverage at the same time.

Subject to the Exception below and to all of the other terms of this Plan, the date Your dependent coverage starts depends on when You elect to enroll Your Initial Dependents and agree to make any required payments. If You do this on or before Your Eligibility Date, the dependent's coverage is scheduled to start on the later of Your eligibility date and the date you become covered for Employee coverage.

If You do this within the Enrollment Period, the coverage is scheduled to start on the date You become covered for Employee coverage.

If You do this after the Enrollment Period ends, Your dependent coverage is subject to Proof of Insurability and will not start until We approve that Proof of Insurability in writing.

Once You have dependent child coverage for Your Initial Dependent child(ren) any Newly Acquired Dependent children will be covered as of the date he or she is first eligible.

If Proof of Insurability is required for dependent benefits as explained above, those benefits will not be scheduled to start until You give Us Proof of Insurability that the dependent is insurable. Once We have approved that Proof of Insurability, those benefits will be scheduled to start on the effective date shown in the endorsement section of Your application.

B005.0070

**Exception** We will postpone the effective date of a dependent's, other than a newborn child's, coverage if, on that date, he or she is: (1) confined to a hospital or other health care facility; (2) home confined; or (3) unable to perform two or more Activities of Daily Living. In that case, We will postpone the effective date of his or her coverage until the day after the date: (a) of his or her discharge from such facility; (b) his or her home confinement ends; or (c) he or she is no longer requires assistance with two or more Activities of Daily Living. If a dependent was covered under a prior plan at transfer, this language will not apply to the amount of coverage that was in force with the prior plan. This exception does not apply to adopted children and step-children.

B044.0010

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### **When Dependent Coverage Ends**

Dependent coverage ends for all of Your dependents when Your Employee coverage ends. Dependent coverage also ends for all of Your dependents when You stop being a member of a class of Employees eligible for such coverage. And, it ends when this Plan ends, or when dependent coverage is dropped from this Plan for all Employees or for Your class.

If You are required to pay all or part of the cost of dependent coverage, and You fail to do so, Your dependent coverage ends. It ends on the last day of the period for which You made the required payments, unless coverage ends earlier for other reasons.

Your dependent's coverage ends when he or she stops being an eligible dependent. This happens to a child at 12:01 A.M. on the date the child attains this Plan's age limit, when he or she marries, or when a step-child is no longer dependent on You for support and maintenance. It happens to a spouse: (1) when a marriage ends in legal divorce or annulment; and (2) at 12:01 A.M. on the date the spouse reaches the limiting age, if applicable.

B005.0075-R

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## **CRITICAL ILLNESS COVERAGE**

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This Certificate includes the Schedule of Benefits form. Your class and benefit options are shown in the Schedule of Benefits that applies to You.

Subject to all of this Plan's terms, We will pay the benefits described below if a Covered Person is Diagnosed with a listed Critical Illness on or after the date he or she becomes covered by this Plan.

This Plan pays no Critical Illness benefits for any condition other than those listed below in Covered Critical Illnesses.

B005.0083

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### **Critical Illness Benefits**

This Plan will pay a benefit based on the benefit amount for which a Covered Person is covered. The benefit will be subject to all of the terms of this Plan.

This Plan only pays benefits for the occurrence of the Critical Illnesses listed and defined in the Covered Critical Illnesses section below.

Each Critical Illness must occur while the Covered Person is covered by this Plan. This Plan deems each Critical Illness to occur on the date described for each Critical Illness in the Covered Critical Illnesses section below.

Where one Critical Illness is caused by or contributes to another Critical Illness, only one benefit is payable. We will pay the greater of the benefits payable. If the amount payable for each Critical Illness is the same, You may choose which benefit to receive.

This Plan may pay a different level of benefits for the First Occurrence and the Recurrence of a Critical Illness. For some Critical Illnesses We pay no benefits for a Recurrence. The benefit levels are shown in the Schedule of Benefits.

By First Occurrence We mean the first time a Covered Person is Diagnosed with a Critical Illness while insured by this Plan. By Recurrence, We mean the second time a Covered Person is diagnosed with the same Critical Illness while insured by this Plan. We pay no benefits for occurrences beyond the second time.

B005.0084

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## Covered Critical Illnesses

B005.0086

### Cancer Related Conditions

B005.0087

**Benign Brain Tumor** We pay a benefit if a Covered Person is Diagnosed with a Benign Brain Tumor, which means a non-cancerous brain tumor confirmed by the examination of tissue (biopsy or surgical excision) or specific neuroradiological examination. The tumor must result in persistent neurological deficits, including but not limited to:

- loss of vision;
- loss of hearing; or
- balance disruption

We do not consider the following to be Benign Brain Tumors:

- tumors of the skull;
- pituitary adenomas; and
- germinomas.

We deem a Benign Brain Tumor to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B005.0088

**Carcinoma in Situ** We pay a benefit if a Covered Person is Diagnosed with Carcinoma In Situ, which means early forms of cancer that have not invaded surrounding tissue. Any malignant tumor classified as less than T1NOMO under TNM classification is considered Carcinoma in Situ. Carcinomas in Situ can include early forms of many common cancers such as breast and prostate cancer.

We do not pay a benefit under this provision for:

- Pre-malignant growths or lesions, such as dysplasia or Intraepithelial neoplasia;
- Any benign tumor or polyp;
- Carcinoma in Situ of the skin

Diagnosis of Carcinoma in Situ must be based on microscopic (histologic) exam of: (a) fixed tissues; or (b) preparations of blood or bone marrow. Such exam must be documented in a written report by a Doctor who is Board Certified in pathology.

We deem Carcinoma in Situ to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

"TNM classification" means the classification standards for cancer developed by the American Joint Committee on Cancer.

B005.0089

**Invasive Cancer** We pay a benefit if a Covered Person is Diagnosed with Invasive Cancer, which means a malignant tumor which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of neighboring tissue.

Invasive Cancer also includes leukemia and lymphoma.

Invasive Cancer must be supported by pathological diagnosis.

We do not pay a benefit under this provision for:

- Pre-malignant growths or lesions, such as dysplasia or intraepithelial neoplasia;
- Any benign tumor or polyp;
- Any condition that is Carcinoma in Situ.
- Any skin cancer, including carcinoma in situ of the skin, unless there is metastasis.

Diagnosis of Invasive Cancer must be based on microscopic (histologic) exam of: (a) fixed tissues; or (b) preparations of blood or bone marrow. Such exam must be documented in a written report by a Doctor who is Board Certified in pathology.

We deem Invasive Cancer to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B005.0090

**Skin Cancer** We pay a benefit if a Covered Person is Diagnosed with the types of Skin Cancer known as either basal cell carcinoma or squamous cell carcinoma. We don't pay a benefit under this provision for any other type of skin cancer. We deem Skin Cancer to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

We limit what We pay to one benefit in a Covered Person's lifetime.

B005.0091

## Vascular Conditions

B005.0123

**Arteriosclerosis** We pay a benefit if a Covered Person is diagnosed with Arteriosclerosis, which means blockage of a coronary artery of sufficient severity to require one or more coronary artery bypass graft(s).

Diagnosis must include demonstrated need for intervention.

We deem Arteriosclerosis to occur on the date a Doctor of appropriate specialty makes a Diagnosis of Arteriosclerosis of sufficient severity to warrant one or more coronary artery bypass graft(s).

B005.0092

**Heart Attack** We pay a benefit if a Covered Person is Diagnosed with a Heart Attack, which means death of heart muscle due to inadequate blood supply. Symptoms of cardiac ischemia must be present, as well as two or more of the following criteria for acute myocardial infarction:

- (1) typical clinical symptoms such as central chest pain;
- (2) diagnostic increase of specific cardiac markers;
- (3) new electrocardiographic changes indicative of new ischemia (new ST-T changes or new left bundle branch block (LBBB);
- (4) development of pathological Q waves in the ECG; or
- (5) imaging evidence of new loss of viable myocardium or new regional wall motion abnormality.

Sudden Cardiac Arrest is not a Heart Attack.

Proof of Heart Attack requires submission of medical records. We deem a heart attack to occur on the date a Doctor of appropriate specialty makes a Diagnosis. A Heart Attack that results in death or is Diagnosed after death will be covered under this provision.

We don't pay a benefit for a Heart Attack that occurs during a medical procedure, including, but not limited to, surgery.

B005.0093

**Heart Failure** We pay a benefit if a Covered Person is Diagnosed with Heart Failure. By Heart Failure We mean the irreversible failure of the heart, which requires a human to human heart, heart/lung or heart combined with any other organ transplant determined to be Medically Necessary by a Doctor of the appropriate specialty.

We deem Heart Failure to occur on the date the Covered Person is accepted onto the transplant waiting list of a recognized transplant program in the United States. We pay the benefit whether or not the transplant is ever performed. If the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on the waiting list of a recognized transplant program, the waiting list requirement will be waived. In this instance We deem Heart Failure to occur on the date a Doctor of appropriate specialty deems the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on a waiting list of a recognized transplant program in the United States.

B005.0094

**Stroke** We pay a benefit if a Covered Person is diagnosed with a Stroke, which means death of brain tissue due to an acute cerebrovascular event. All of the following criteria must be satisfied: (1) clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage; (2) clear evidence on a CT, MRI or similar imaging techniques that a stroke has occurred; and (3) permanent neurologic deficit measured 30 days or more after the event that results in functional impairment rated at a score of two or higher on the Modified Rankin Scale for stroke outcome. The term does not mean symptoms due to: (a) transient ischemic attack; (b) migraine; (c) hypoxia; (d) traumatic injury to brain tissue or blood vessels; and (e) vascular disease affecting the eye, optic nerve or vestibular functions.

Diagnosis of Stroke must be:

- (1) confirmed in writing by a Doctor of the appropriate specialty; and
- (2) based on medical records. These records must show objective evidence of significant neurological impairment.

Such impairment must be documented by meeting all of the following criteria:

- (a) clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage;
- (b) clear evidence on a CT, MRI or similar imaging techniques that a stroke has occurred; and
- (c) permanent neurologic deficit measured 30 days or more after the event that results in a score of two or higher on the Modified Rankin Scale for stroke outcome.

We deem the Stroke to occur on the date of the event. In the event of death, an autopsy confirmation and/or death certificate identifying Stroke as the cause of death will be accepted.

B005.0095

### **Neurological Conditions**

B005.0096

**Alzheimer's Disease** We pay a benefit if a Covered Person is Diagnosed with Alzheimer's Disease, which means a progressive degenerative disease of the brain that is Diagnosed by a Board Certified psychiatrist or Board Certified neurologist as Alzheimer's Disease. The Diagnosis must be supported by medical evidence that the Covered Person exhibits the loss of intellectual capacity resulting in impairment of memory and judgment as documented and demonstrated by cognitive testing and supported by neuroradiological tests (e.g., CT Scan, MRI, PET of the brain). This impairment must result in a significant reduction in mental and social functioning, resulting in the Covered Person's inability to permanently perform two or more of the Activities of Daily Living without the continuing assistance of another person. No other dementing organic brain disorders or psychiatric illnesses are included in this definition.

Activities of Daily Living include:

- Bathing: wash in a tub or shower; or take a sponge bath; and towel dry.
- Dressing: put on and take off all clothes; and those medically necessary braces or prosthetic limbs usually worn; and fasten or unfasten them.
- Toileting: get to and from and on and off the toilet; to maintain personal hygiene; and care for clothes.
- Transferring: move in and out of a chair or bed.
- Continence: control bowel and bladder function; or, in the event of incontinence, maintain personal hygiene.
- Eating: get food into the body by any means once it has been prepared and made available.

Diagnosis must be based on clinical and/or diagnostic findings as supported by the Covered Person's medical records. We deem Alzheimer's Disease to occur on the date a Doctor of appropriate specialty makes a Diagnosis. The Diagnosis must occur while the Covered Person is insured under this Plan.

B005.0097

**Amyotrophic Lateral Sclerosis (also known as ALS or Lou Gehrig's Disease)** We pay a benefit if a Covered Person is Diagnosed with Amyotrophic Lateral Sclerosis (ALS), which means motor neuron disease, marked by muscular weakness and atrophy with spasticity and hyperreflexia due to a loss of motor neurons of the spinal cord, medulla and cortex.

We deem ALS to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B005.0098

**Huntington's Disease** We pay a benefit if a Covered Person is Diagnosed with Huntington's Disease, which is a neurodegenerative genetic disorder that affects muscle coordination and leads to cognitive decline and psychiatric problems.

Diagnosis must document symptoms and verify the presence of the gene via genetic testing. We don't pay a benefit for the presence of the Huntington's Disease gene in absence of symptoms.

Symptoms include

- Personality changes, mood swings and depression;

- Forgetfulness and impaired judgment;
- Unsteady gait and involuntary movements;
- Slurred speech and difficulty in swallowing.

We deem Huntington's Disease to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

The Diagnosis must occur while the Covered Person is insured under this Plan.

B005.0099

**Multiple Sclerosis (MS)** We pay a benefit if a Covered Person is diagnosed with Multiple Sclerosis (MS), which means demonstrated neurological deficits that have been present for 6 months or more. Diagnosis must be made on the basis of:

- (1) neurological examination demonstrating functional impairments;
- (2) imaging studies of the brain or spine demonstrating lesions consistent with MS; and
- (3) analysis of cerebrospinal fluid consistent with the diagnosis.

We deem MS to occur on the date a Doctor of appropriate specialty makes a Diagnosis. Diagnosis must occur while the Covered Person is insured under this Plan.

B005.0100

**Advanced Parkinson's Disease** We pay a benefit if a Covered Person is Diagnosed with Advanced Parkinson's Disease, which means Parkinson's Disease that has progressed to Stage 4, as Diagnosed by a Board Certified, or board-eligible, neurologist based on abnormal findings from neurological examination, cognitive testing, and results of imaging studies.

We deem Advanced Parkinson's Disease to occur on the date a Doctor of appropriate specialty makes a Diagnosis that the person has progressed to Stage 4. The Diagnosis must occur while the Covered Person is covered under this Plan.

B005.0101

### Childhood Conditions

B005.0102

**Cerebral Palsy** We pay a benefit if a Covered Dependent Child is Diagnosed with Cerebral Palsy, which means a group of disorders of the development of movement and posture causing activity limitation that are attributed to progressive disturbances that occurred in the developing fetal or infant brain. The motor disorders of cerebral palsy are often accompanied by disturbances of sensation, cognition, communication, perception and/or behavior and/or a seizure disorder. Other similar conditions such as degenerative nerve disorders, genetic diseases, muscle diseases, metabolic disorders, nervous system tumors, coagulation disorders, or other injuries or disorders which delay early development, but can be outgrown, are not included in this definition.

We deem Cerebral Palsy to occur on the first date after live birth where a Doctor of appropriate specialty makes a Diagnosis.

B005.0103

**Cleft Lip or Palate** We pay a benefit if a Covered Dependent Child is Diagnosed with Cleft Lip or Cleft Palate. A Cleft Lip appears as a narrow opening or gap in the skin of the upper lip that extends all the way to the base of the nose. A Cleft Palate is an opening between the roof of the mouth and the nasal cavity, including clefts that occur on one side of the mouth or both sides.

We pay a benefit for either a Cleft Lip or Cleft Palate, but not both.

We deem Cleft Lip or Cleft Palate to occur on the first date after live birth where a Doctor of appropriate specialty makes a definite clinical Diagnosis of a cleft lip or palate.

B005.0104

**Clubfoot** We pay a benefit if a Covered Dependent Child is Diagnosed with Clubfoot, which means a congenital deformity of the foot.

We pay the benefit only once even if Clubfoot is present in both of the child's feet.

We deem Clubfoot to occur on the first day after live birth where a Doctor of appropriate specialty makes a definite Diagnosis of Clubfoot.

B005.0105

**Cystic Fibrosis** We pay a benefit if a Covered Dependent Child is Diagnosed with Cystic Fibrosis, which means chronic lung disease and pancreatic insufficiency. The Diagnosis of Cystic Fibrosis made via sweat test is based upon sweat chloride concentrations greater than 60 mmol/L.

We deem Cystic Fibrosis to occur on the first date after live birth where Cystic Fibrosis has been definitively Diagnosed by a Doctor of appropriate specialty via sweat test.

B005.0106

**Down Syndrome** We pay a benefit if a Covered Dependent Child is Diagnosed with Down Syndrome, which means a Diagnosis of Down Syndrome through study of the 21st chromosome. Down Syndrome includes:

- Trisomy - an individual has three instead of two number 21 chromosomes;
- Translocation - an extra part of the 21st chromosome is attached to another chromosome;
- Mosaicism - the individual has an extra 21st chromosome in only some of the cells but not all of them. The other cells have the usual pair of 21st chromosomes.

We deem Down Syndrome to occur on the first date after live birth where a Doctor of appropriate specialty completes a chromosome test that positively reveals Down Syndrome.

B005.0107

**Muscular Dystrophy** We pay a benefit if a Covered Dependent Child is Diagnosed with Muscular Dystrophy, which means a hereditary condition that is marked by progressive weakening and wasting of muscles. The Covered Dependent Child must have well defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

We deem Muscular Dystrophy to occur on the first date after live birth where a Doctor of appropriate specialty makes a Diagnosis.

B005.0108

**Spina Bifida** We pay a benefit if a Covered Dependent Child is Diagnosed with Spina Bifida, which means either of the following types of Spina Bifida:

- (1) Meningocele - the protective coatings (meninges) come through the open part of the spine like a sac that is pushed out. Cerebrospinal fluid is in the sac and there is usually no nerve damage.
- (2) Myelomeningocele - This occurs when the meninges (protective covering of the spinal cord) and spinal nerves come through the open part of the spine.

We pay no benefits for spina bifida occulta.

We deem Spina Bifida to occur on the first date after live birth where a Doctor of appropriate specialty makes a Diagnosis

B005.0109

**Type 1 Diabetes** We pay a benefit if a Covered Dependent Child is Diagnosed with Type 1 Diabetes, which means the child has a total insulin deficiency and a continuous dependence on exogenous insulin for survival. Dependence on insulin must persist for a continuous period of at least 3 months.

We deem Type 1 Diabetes to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B005.0110

#### **Other Critical Illnesses**

B005.0111

**Addison's Disease** We pay a benefit if a Covered Person is Diagnosed with Addison's disease, which means an endocrine or hormonal disorder resulting in the adrenal glands not producing sufficient cortisol.

Diagnosis must be made by laboratory tests designed to show insufficient levels of cortisol.

We deem Addison's Disease to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B005.0112

**Coma** We pay a benefit if a Covered Person is Diagnosed with a Coma, which means a state of complete mental unresponsiveness with no evidence of appropriate responses to stimulation, lasting for a period of 7 or more consecutive days and characterized by the absence of eye opening, verbal response and motor response. The condition must require intubation for respiratory assistance. This benefit is not payable for a medically induced Coma.

We deem a Coma to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B005.0113

**Kidney Failure** We pay a benefit if a Covered Person is Diagnosed with Kidney Failure, which means chronic irreversible failure of both kidneys to function, as a result of which either weekly or bi-weekly renal or peritoneal dialysis is started, or renal transplant is performed.

Proof of Kidney Failure requires submission of medical records. Diagnosis of Kidney Failure will be deemed to occur on the earlier of the date: (a) renal or peritoneal dialysis is started; or (b) the date the Covered Person is accepted onto the kidney transplant waiting list of a recognized transplant program in the United States. If the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on the waiting list of a recognized transplant program, the waiting list requirement will be waived. In this instance We deem Kidney Failure to occur on the date a Doctor of appropriate specialty deems the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on a waiting list of a recognized transplant program in the United States.

B005.0114

**Loss of Hearing** We pay a benefit if a Covered Person is Diagnosed with Loss of Hearing, which means clinically-proven irreversible loss of hearing in both ears, with an auditory threshold of more than 90 decibels, as a result of illness or injury that has continued without interruption for at least 6 consecutive months after Diagnosis.

No benefit will be paid if, in general medical opinion, surgery, a hearing aid, device, or implant could result in the partial or total restoration of hearing.

The Diagnosis must be made by physical examination by an licensed audiologist.

A Covered Dependent Child must be at least 3 years old on the date of Diagnosis in order to receive a benefit. However, if a Covered Dependent Child is Diagnosed prior to age 3, We will pay a benefit if the initial Diagnosis occurred while insured by this Plan, and the Diagnosis is confirmed on or after the child reaches age 3 and remains insured by this Plan.

We deem Loss of Hearing to occur on the date on which a licensed audiologist physically examines the Covered Person and certifies that the Covered Person meets the definition above.

B005.0115

**Loss of Sight** We pay a benefit if a Covered Person is diagnosed with Loss of Sight, based on best corrected visual acuity of 20/400 or less or visual field of 20 degrees or less in the better eye. No benefit will be paid if, in general medical opinion, surgery, device, or implant could result in the partial or total restoration of sight.

A Covered Dependent Child must be at least 3 years old on the date of Diagnosis in order to receive a benefit. However, if a Covered Dependent Child is Diagnosed prior to age 3, We will pay a benefit if the initial diagnosis occurred while insured by this Plan, and the Diagnosis is confirmed on or after the child reaches age 3 and remains insured by this Plan.

We deem Loss of Sight to occur on the date on which a licensed ophthalmologist physically examines the Covered Person and certifies that the Covered Person has best corrected visual acuity of 20/400 or less or visual field of 20 degrees or less in the better eye.

B005.0116

**Loss of Speech** We pay a benefit if a Covered Person is Diagnosed with Loss of Speech, which means the clinically proven total, permanent and irreversible loss of the ability to speak as a result of Illness or injury that has continued without interruption for a period of at least 6 consecutive months.

No benefit will be payable if, in general medical opinion, surgery, a device or implant could result in the partial or total restoration of speech.

The Diagnosis must be made by physical examination by a speech pathologist.

A Covered Dependent Child must be at least 3 years old on the date of Diagnosis in order to receive a benefit. However, if a Covered Dependent Child is Diagnosed prior to age 3, We will pay a benefit if the initial diagnosis occurred while insured by this Plan, and the Diagnosis is confirmed on or after the child reaches age 3 and remains insured by this Plan.

We deem Loss of Speech to occur on the date on which a Doctor of appropriate specialty physically examines the Covered Person and certifies that the Covered Person meets the definition above.

B005.0117

**Major Organ Failure** We pay a benefit if a Covered Person is Diagnosed with Major Organ Failure. By Major Organ Failure We mean the irreversible failure of both lungs, liver, pancreas, or bone marrow, which requires a human to human transplant determined to be Medically Necessary by a Doctor of the appropriate specialty.

We deem Major Organ Failure to occur on the date the Covered Person is accepted onto the transplant waiting list of a recognized transplant program in the United States. We pay the benefit whether or not the transplant is ever performed. If the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on the waiting list of a recognized transplant program, the waiting list requirement will be waived. In this instance We deem Major Organ Failure to occur on the date a Doctor of appropriate specialty deems the Covered Person is too ill for a transplant, but otherwise meets the criteria for being on a waiting list of a recognized transplant program in the United States.

We don't pay a benefit under both this provision and the Heart Failure provision at the same time.

We pay no benefits for autologous bone marrow transplants.

B005.0118

**Permanent Paralysis** We pay a benefit if a Covered Person is Diagnosed with Permanent Paralysis, which means a complete and irreversible condition marked by loss of muscle function in any combination of arms and legs. Permanent Paralysis must be the direct result of a Sickness or Injury, other than a Stroke.

We pay 100% of the benefit amount for the Permanent Paralysis of two or more limbs. We pay 50% of the benefit amount for the Permanent Paralysis of one limb.

We deem Permanent Paralysis to occur on the date a Doctor of appropriate specialty makes a Diagnosis.

B005.0119

**Severe Burns** We pay a benefit if a Covered Person is Diagnosed with Severe Burns, which means full-thickness or third-degree burn, as determined by a Doctor covering at least 25% of the body. A full-thickness or third-degree burn is the destruction of the skin through the entire thickness or depth of the dermis and possibly into underlying tissues, with loss of fluid and sometimes shock, by means of exposure to fire, heat, caustics, electricity or radiation.

We deem Severe Burns to occur on the date of the Injury.

B005.0120

#### **Other Benefits**

B005.0121

**Cancer Vaccine** We will pay the amount shown in the Schedule of Benefits if a Covered Person receives any Cancer Vaccine approved by the Food and Drug Administration (FDA) for prevention of cancer.

B005.0122

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## Limitations

B005.0124

**Age Reduction** The Covered Person's benefit amount will be reduced when You reach certain ages. These reductions are shown in the Schedule of Benefits. The dependent's benefit amount will be reduced on a pro rata basis when Your benefit amount is reduced.

B005.0126

**Proof Of Insurability** The Covered Person's benefit amount, part of it, or increases in it, may not become effective until he or she submits Proof of Insurability to Us. We must approve such Proof of Insurability in writing. These requirements are shown in the Schedule of Benefits.

B005.0127

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## Exclusions

1) This Plan will not pay benefits for any Critical Illness:

- That is not listed as a Critical Illness in the section entitled Covered Critical Illnesses.
- Caused by, contributed to by, or resulting from: (1) participating in a felony, riot or insurrection; (2) intentionally causing a self-inflicted Injury; (3) committing or attempting to commit suicide while sane or insane; (4) engaging in any illegal occupation; or (5) serving in the armed forces or any auxiliary unit of the armed forces of any country.
- Caused by, contributed to by, or resulting from voluntary use of any poison, chemical, prescription or non-prescription drug or controlled substance unless: (1) it was prescribed for the Covered Person by a Doctor, and (2) it was used as prescribed. In the case of a non-prescription drug, this Plan does not pay for any Critical Illness resulting from or contributed to by use in a manner inconsistent with package instructions. "Controlled substance" means anything called a controlled substance in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended from time to time.
- Arising from war or act of war, even if war is not declared.
- For which Diagnosis is made outside the United States, unless the Diagnosis is confirmed in the United States. In that case, the Critical Illness will be deemed to occur on the date the Diagnosis was made outside the United States.
- That is Diagnosed while the person is not covered by this Plan.
- For which Diagnosis is made by a Doctor who is the Covered Person, his or her spouse, child, parent, sibling or business associate.
- For which Diagnosis is made while the Covered Person is not alive, unless otherwise specified under Covered Critical Illnesses.

2) This Plan will not pay benefits for the First Occurrence of a Critical Illness if it occurs less than 3 months after the First Occurrence of a related Critical Illness for which this Plan paid benefits. By related we mean either: (a) both Critical Illnesses are contained within the Cancer Related Conditions category; or (b) both Critical Illnesses are contained within the Vascular Conditions category; or (c) both Critical Illnesses are contained within the Childhood Conditions category.

3) This Plan will not pay benefits for a Recurrence of a Critical Illness unless the Covered Person has not exhibited symptoms or received care or treatment for that Critical Illness for at least 12 months in a row prior to the Recurrence. For purposes of this exclusion, care or treatment does not include: (1) preventive medications in the absence of disease; and (2) routine scheduled follow-up visits to a Doctor.

4) This Plan will not pay benefits for more than one Recurrence of any Critical Illness.

B044.0033

# SCHEDULE OF BENEFITS

## CRITICAL ILLNESS COVERAGE

Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this Schedule of Benefits is attached to the Certificate. This Schedule of Benefits replaces any previously issued Schedule of Benefits.

B005.0141

**Initial Election** When You first become eligible for this Plan You may choose to become covered for one of the plans described below and pay the required premium.

You may request to switch to another plan at any time. But, We will require Proof of Insurability before You switch to another plan which provides greater benefits. You must notify the Employer of any desired switch and pay the required premium.

B005.0237

Benefit Levels	Critical Illness	% of Benefit Amount for First Occurrence	% of Benefit Amount for Recurrence
<b><u>Cancer Related Conditions:</u></b>			
	Benign Brain Tumor	75%	Not Covered
	Carcinoma in Situ	30%	Not Covered
	Invasive Cancer	100%	50%
	Skin Cancer	\$250.00	Not Covered
<b><u>Vascular Conditions:</u></b>			
	Arteriosclerosis	30%	Not Covered
	Heart Attack	100%	50%
	Heart Failure	100%	50%
	Stroke	100%	50%
<b><u>Neurological Conditions:</u></b>			
	Alzheimer's Disease for Covered Person	50%	Not Covered
	ALS (Lou Gehrig's Disease)	100%	Not Covered
	Huntington's Disease	30%	Not Covered
	Multiple Sclerosis	30%	Not Covered
	Advanced Parkinson's Disease	100%	Not Covered

**Childhood  
Conditions:**  
(applies only to  
covered dependent  
children)

<b>Cerebral Palsy</b>	100%	Not Covered
<b>Cleft lip/cleft palate</b>	100%	Not Covered
<b>Club Foot</b>	100%	Not Covered
<b>Cystic Fibrosis</b>	100%	Not Covered
<b>Down's Syndrome</b>	100%	Not Covered
<b>Muscular Dystrophy</b>	100%	Not Covered
<b>Spina Bifida</b>	100%	Not Covered
<b>Type 1 Diabetes</b>	100%	Not Covered

**Other Conditions:**

<b>Addison's Disease</b>	30%	Not Covered
<b>Coma</b>	100%	Not Covered
<b>Kidney Failure</b>	100%	50%
<b>Loss of Hearing</b>	100%	Not Covered
<b>Loss of Sight</b>	100%	Not Covered
<b>Loss of Speech</b>	100%	Not Covered
<b>Major Organ Failure</b>	100%	50%
<b>Permanent Paralysis</b>	100% for 2 or more limbs; 50% for 1 limb	Not Covered
<b>Severe Burns</b>	100%	Not Covered
<b>Cancer Vaccine</b>	\$50.00 per lifetime	

**EMPLOYEE VOLUNTARY CRITICAL ILLNESS COVERAGE**

GC-SCH-CI-14

B005.0294

**Critical Illness Plan A** ..... \$10,000.00  
**Benefit Amount**

B005.0316

**Critical Illness Plan B** ..... \$20,000.00  
**Benefit Amount**

B005.0314

**Reduction of Critical Illness Benefit Amount Based On Age** If You are less than age 70 when Your coverage under this Plan starts, Your benefit amount will be reduced. It will be reduced on the date you reach age 70, by 50% of that amount. Reduced amounts will be rounded to the nearest dollar. But, in no case will such amount be less than \$1,000.00.

This reduction also applies to Your initial benefit amount if Your coverage starts on or after the date You reach age 70.

B005.0318

GC-SCH-CI-14

**Proof of Insurability Requirements** Proof of Insurability requirements may apply to this coverage. Such requirements may apply to the full benefit amount, or just part of it. When Proof of Insurability requirements apply, it means You must submit to Us, Proof of Insurability, and We must approve the Proof of Insurability in writing before the coverage, or the specified part becomes effective.

We require Proof of Insurability as follows:

We require Proof of Insurability before We will cover You if You enroll for Critical Illness coverage after the time allowed for enrolling as specified in this Plan.

We require Proof of Insurability when You switch from Your current plan of Critical Illness coverage to a plan with a higher benefit amount.

Proof of Insurability requirements vary depending on Your age. If You are less than age 70, You must provide Proof of Insurability for amounts of Critical Illness coverage in excess of \$.00.

If You are age 70 or over, You must provide Proof of Insurability for all amounts of Critical Illness coverage.

B005.0321

#### DEPENDENT VOLUNTARY CRITICAL ILLNESS COVERAGE

GC-SCH-CI-14

B005.0400

**Dependent Spouse Critical Illness Benefit Amount** \$10,000.00 not to exceed 50% of Your Critical Illness Benefit Amount.

B005.0403

**Dependent Child Critical Illness Benefit Amount** \$10,000.00 not to exceed 50% of Your Critical Illness Benefit Amount.

B005.0427

**Reduction of Critical Illness Benefit Amount Based On Employee's Age** Your dependent's Critical Illness Benefit Amount is reduced in the same manner as Your Critical Illness Benefit Amount.

B005.0442

**Dependent Spouse Proof of Insurability Requirements** Proof of Insurability requirements may apply to this coverage. Such requirements may apply to the full benefit amount, or just part of it. When Proof of Insurability requirements apply, it means You must submit to Us, Proof of Insurability for Your dependent spouse, and We must approve the Proof of Insurability in writing before the coverage, or the specified part becomes effective.

We require Proof of Insurability as follows:

We require Proof of Insurability before We will cover Your spouse if You enroll him or her for Critical Illness coverage after the time allowed for enrolling as specified in this Plan.

We require Proof of Insurability for Your spouse when You switch from Your current plan of dependent spouse Critical Illness coverage to a plan with a higher benefit amount.

GC-SCH-CI-14

Proof of Insurability requirements vary depending on Your spouse's age. If Your spouse is less than age 70, You must provide Proof of Insurability for Your spouse for amounts of dependent spouse Critical Illness coverage in excess of \$.00.

If Your spouse is age 70 or over, You must provide Proof of Insurability for Your spouse for all amounts of dependent spouse Critical Illness coverage.

B005.0445

### **Changes To Coverage**

**Changes in Coverage Amounts** If You are not Actively At Work on a Full-Time basis, any change in Your amount of coverage or the amount of coverage on a covered dependent will not become effective prior to the date You return to Active Work on a Full-Time basis.

**Changes in Insurance Classification** If Your classification changes, coverage will not be changed to the new amount until the first day on which You are: (1) Actively At Work on a Full-Time basis; and (2) make a contribution, if required, for the new classification.

If a contribution is required for the new classification for which a larger amount of coverage is provided, You must make the required contribution for the new amount within 31 days of the change. If You do not make the required contribution within 31 days of the change or within 31 days of becoming Actively At Work on a Full-Time basis, if You are not Actively At Work on a Full-Time basis, when Your classification changes, no increase will be allowed due to such change or any later change. In that case, in order to become covered for the larger amount, You must: (1) make the required contribution for the new amount; and (2) furnish Proof of Insurability to Us, which We approve in writing.

If the coverage amount was previously reduced because of age or retirement, it will be retained at the reduced amount.

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## CERTIFICATE RIDER - Portability Privilege

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Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends this Plan by the addition of the following:

### PORTABILITY PRIVILEGE

**Definition:** As used in this provision, the terms "port" and "to port" mean to choose a portable certificate of coverage which provides group Critical Illness coverage.

**Portability Conditions:** Portability is subject to all of the Conditions described below.

- You may port if Your coverage under this Plan ends because: (1) You have terminated employment; (2) You stop being a member of an eligible class of Employees; or (3) this Plan ends.
- You may **not** port Your coverage if You have reached Your 70th birthday on the date coverage under this Plan ends.
- You may **not** port coverage for any of Your dependents if he or she has reached his or her 70th birthday on the date coverage under this Plan ends.
- You may **not** port if coverage under this Plan ends due to Your failure to pay any required premium.

**Portability Options:** You may port Your Critical Illness coverage, subject to any benefit amount reductions based on age, less the amount of any Critical Illness benefits paid by this Plan.

You may port Your dependent's Critical Illness coverage, subject to any benefit amount reductions based on Your age, less the amount of any Critical Illness benefits paid by this Plan.

You may port: (1) Your coverage only; (2) Your coverage and coverage of Your covered Spouse; (3) Your coverage and the coverage of all of Your covered dependents; or (4) if You are a single parent, Your coverage and the coverage of all of Your covered dependent children. No other combinations will be allowed.

A dependent must be covered as of the date Your coverage under this Plan ends in order to be eligible for portability.

If You die while covered for dependent Critical Illness coverage, Your Spouse may port Your dependent Critical Illness coverage as described above. Your Spouse and dependent children must be covered under this Plan on the date of Your death. But, this option is not available if: (1) there is no surviving Spouse; or (2) Your surviving Spouse has reached his or her 70th birthday on the date of Your death.

**The Portable Certificate of Coverage:** The portable certificate of coverage provides group Critical Illness. The benefits provided by the portable certificate of coverage are the same as the benefits provided by this Plan. The portable certificate provides seamless coverage. Benefit limits, maximums and timeframes do not reset when someone becomes covered under the portable certificate. The premium for the portable certificate of coverage will be based on: (1) the Covered Person's rate class under this Plan; and (2) Your surviving Spouse's age bracket as shown in the Critical Illness Portability Coverage Premium Notice.

**How to Port:** You or Your surviving Spouse must: (1) apply to Us in writing; and (2) pay the required premium. You or Your surviving Spouse must do this within 31 days from the date Your coverage under this Plan ends. We will not ask for proof that You or Your surviving Spouse are in good health.

This rider is a part of this Certificate. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this Certificate.

**The Guardian** Life Insurance Company of America

Stuart J Shaw  
Vice President, Risk Mgt. & Chief Actuary

B005.0240

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## **CERTIFICATE RIDER - Wellness Benefit**

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Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends this Plan by the addition of the following:

### **Wellness Benefit**

This Plan will pay a benefit if a Covered Person has one of the following wellness tests or procedures performed.

We limit what we pay to \$50.00 per day of wellness tests or procedures. We limit what we pay to one day per Covered Person per Benefit Year.

By Benefit Year, we mean a 12 month period which starts on January 1st and ends on December 31st of each year.

By Covered Person, we mean You, as the Employee insured under this Plan and Your dependent Spouse and Covered Dependent Child(ren).

This Plan pays this benefit regardless of the results of the test or procedure.

Wellness tests or procedures are limited to:

- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- Cancer genetic mutation test
- CA 15-3 (blood test for breast cancer)
- CA125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest x-ray
- Colonoscopy
- Completion of a smoking cessation program
- Completion of a weight reduction program
- Fasting blood glucose test
- Flexible Sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum cholesterol test to determine level of
- HDL and LDL
- Serum Protein Electrophoresis (blood test for myeloma)
- Stress test on a bicycle or treadmill
- Thermography
- ThinPrep pap test
- Virtual colonoscopy

The Covered Person must submit proof of the test or procedure.

This rider is a part of this Certificate. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this Certificate.

**The Guardian** Life Insurance Company of America

*Stuart J Shaw*  
Vice President, Risk Mgt. & Chief Actuary

B005.0462

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**SUMMARY PLAN DESCRIPTION SUPPLEMENT TO CERTIFICATE**

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You participate in a single or multiple employer insured Welfare Plan. This supplement and your certificate of insurance together may constitute the Summary Plan Description as required by the Employee Retirement Income Security Act of 1974 (ERISA). This supplement should be retained with your certificate.

- **Name of Plan:**

NATIONAL SEATING & MOBILITY Plan

- **Employer's Name:** (Plan Sponsor)

NATIONAL SEATING & MOBILITY

**Address:** 320 PREMIER COURT  
FRANKLIN TN 37067

**Phone Number:** 423-756-2268

- If you participate in a multiple employer insured Welfare Plan, you may obtain a complete list of the employers sponsoring the plan upon written request to the plan administrator. You may also receive information as to whether a particular employer is a plan sponsor, and if the employer is a plan sponsor, the sponsor's address.

- **IRS Employer Identification Number (EIN):**621400785

- **Plan Number:** 509

- **Type of Administration:**contract administration

- **Plan Administrator:** (if other than Plan Sponsor)

NATIONAL SEATING & MOBILITY

**Address:** 320 PREMIER COURT  
FRANKLIN TN 37067

**Phone Number:** 423-756-2268

- **Agent for the Service of Legal Process:**

NATIONAL SEATING & MOBILITY

**Address:** 320 PREMIER COURT  
FRANKLIN TN 37067

**Phone Number:** 423-756-2268

(Legal process may also be served on the Plan Administrator.)

- If the plan is maintained pursuant to one or more collective bargaining agreements, the following information may be obtained by participants and beneficiaries upon written request to the plan administrator, and is available for examination by participants and beneficiaries: a copy of any such collective bargaining agreement; a complete list of the employers and employee organizations sponsoring the plan; and information as to whether a particular employer or employee organization is a sponsor of the plan, and if so, the sponsor's address. For the purpose of this paragraph, a plan is maintained pursuant to a collective bargaining agreement if such agreement controls any duties, rights or benefits under the plan, even though such agreement has been superseded in part for other purposes.
- **Date of End of Record Year:** January 1st .
- **Sources of Contribution:**Contributions to the plan are provided by:
  - the Employer
  - the Employee
  - Both the Employer and the Employee (assuming there are situations where both contribute).
- A class or classes of full-time employees are eligible to apply for insurance provided they have completed the service waiting period established by the employer, if any. Qualified dependents of these employees may also be eligible for insurance. (Your certificate provides details.)
- Participants and beneficiaries under this Plan can obtain, without charge, a copy of procedures governing qualified domestic relations order (QDRO) determinations from the plan administrator.
- **Termination/Amendment/Elimination:**Conditions may exist in the Group Policy where the plan sponsor or others have the authority to terminate the plan, amend or eliminate benefits under the plan. Please see the Plan Administrator for more information regarding these specific conditions and to request a copy of the Group Policy.
- **Assistance:** For information regarding rights under ERISA, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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**The following notice applies if your plan is governed by the Employee Retirement Income Security Act of 1974 and its amendments. This notice is not part of the Guardian plan of insurance or any employer funded benefits, not insured by Guardian.**

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## STATEMENT OF ERISA RIGHTS

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As a participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

### **Receive Information About Your Plan and Benefits**

- (a) Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U. S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- (b) Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- (c) Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

### **Prudent Actions By Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

## Statement of Erisa Rights (Cont.)

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**Enforcement Of Your Rights** If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds that your claim is frivolous.

**Assistance with Questions** If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in your telephone directory or the Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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## Group Health Benefits Claims Procedure

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Plan Administrator.

Guardian is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of the Employee Retirement Income Security Act of 1974 ("ERISA").

**Definitions** "Adverse Benefit Determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit.

"Group Health Benefits" means any accident, cancer, critical illness, specified disease or hospital indemnity coverages which are a part of this plan.

**Timing For Initial Benefit Determination** The benefit determination period begins when a claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the maximum time period shown below. A written or electronic notification of any adverse benefit determination must be provided.

**Claims.** Guardian will provide a benefit determination not later than 30 days after receipt of a claim. If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 30 days after receipt of the claim.

The time period for completing a benefit determination may be extended by up to 15 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 30-day period.

If Guardian extends the time period for making a benefit determination due to a claimant's failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

**Adverse Benefit Determination** If a claim is denied, Guardian will provide a notice that will set forth:

- the specific reason(s) for the adverse determination;
- reference to the specific plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to make the claim valid and an explanation of why such material or information is needed;

## Group Health Benefits Claims Procedure (Cont.)

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- a description of the plan's claim review procedures and the time limits applicable to such procedures, including a statement indicating that the claimant has the right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination;
- identification and description of any specific internal rule, guideline or protocol that was relied upon in making an adverse benefit determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request.

### **Appeal of Adverse Benefit Determinations**

If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal.

Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- the opportunity to submit written comments, documents, records and other information relating to the claim;
- the opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relating to the claim; and
- a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person's subordinate;
- in deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person's subordinate.

Guardian will notify the claimant of its decision regarding review of an appeal as follows:

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## Group Health Benefits Claims Procedure (Cont.)

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**Claims.** Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse benefit determination.

**Alternative Dispute Options** The claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S Department of Labor Office and the State insurance regulatory agency.

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## Termination of This Group Plan

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Your *employer* may terminate this group *plan* at any time by giving us 31 days advance written notice. This *plan* will also end if your *employer* fails to pay a premium due by the end of this grace period.

We may have the option to terminate this *plan* if the number of people insured falls below a certain level.

When this *plan* ends, you may be eligible to continue your insurance coverage. Your rights upon termination of the *plan* are explained in this booklet.

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**The Guardian Life Insurance  
Company of America**  
7 Hanover Square  
New York, New York 10004-2616

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